

		FOR OFF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0036335</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																	
Facility Name: <u>Sparta Terrace</u>		<p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/00</u> to <u>6/30/01</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p>																																																	
Address: <u>1501 Melmar Drive</u> <u>Sparta</u> <u>62886</u>																																																			
<div>NumberCityZip Code</div>																																																			
County: <u>Randolph</u>																																																			
Telephone Number: <u>(618) 443-2122</u> Fax # <u>(618) 443-2339</u>																																																			
IDPA ID Number: <u>363234108003</u>		<div>Officer or Administrator of Provider</div> <div>(Signed) _____ (Date) _____</div> <div>(Type or Print Name) _____</div> <div>(Title) _____</div> <div>Paid Preparer</div> <div>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____</div> <div>(Print Name and Title) _____</div> <div>(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u></div> <div>(Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u></div> <div>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</div>																																																	
Date of Initial License for Current Owners: <u>06/01/90</u>																																																			
Type of Ownership:																																																			
<table><tr><td><input checked="" type="checkbox"/></td><td>VOLUNTARY, NON-PROFIT</td><td><input type="checkbox"/></td><td>PROPRIETARY</td><td><input type="checkbox"/></td><td>GOVERNMENTAL</td></tr><tr><td><input checked="" type="checkbox"/></td><td>Charitable Corp.</td><td><input type="checkbox"/></td><td>Individual</td><td><input type="checkbox"/></td><td>State</td></tr><tr><td><input type="checkbox"/></td><td>Trust</td><td><input type="checkbox"/></td><td>Partnership</td><td><input type="checkbox"/></td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code <u>501(C)(3)</u></td><td><input type="checkbox"/></td><td>Corporation</td><td><input type="checkbox"/></td><td>Other _____</td></tr><tr><td colspan="2"></td><td><input type="checkbox"/></td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td><input type="checkbox"/></td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td><input type="checkbox"/></td><td>Trust</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td><input type="checkbox"/></td><td>Other _____</td><td colspan="2">_____</td></tr></table>				<input checked="" type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL	<input checked="" type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State	<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County	IRS Exemption Code <u>501(C)(3)</u>		<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other _____			<input type="checkbox"/>	"Sub-S" Corp.	_____				<input type="checkbox"/>	Limited Liability Co.	_____				<input type="checkbox"/>	Trust	_____				<input type="checkbox"/>	Other _____	_____	
<input checked="" type="checkbox"/>	VOLUNTARY, NON-PROFIT			<input type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL																																												
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		<input type="checkbox"/>	Limited Liability Co.	_____																																															
		<input type="checkbox"/>	Trust	_____																																															
		<input type="checkbox"/>	Other _____	_____																																															
In the event there are further questions about this report, please contact:																																																			
Name: <u>Michael G. Kaplan</u> Telephone Number: <u>(312) 634-3400</u>																																																			
Please send copies of desk review and audit adjustments to address on this page																																																			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sparta Terrace

0036335 Report Period Beginning: 7/1/00 Ending: 6/30/01

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds <u>N/A</u>					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</u>	7

B. Census-For the entire report period.					
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Public Aid Recipient	Private Pay	Other	Total
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	<u>5,786</u>			<u>5,786</u>
14	TOTALS	<u>5,786</u>			<u>5,786</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.08%

SEE ACCOUNTANTS' COMPILATION REPORT

D. How many bed-hold days during this year were paid by Public Aid?
54 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☒ NO ☐ Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 06/01/90

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 06/01/90 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number of beds certified 0 and days of care provided n/a

Medicare Intermediary n/a

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 06/30/01 Fiscal Year: 06/30/01
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Sparta Terrace # 0036335 Report Period Beginning: 7/1/00 Ending: 6/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	27,274	1,509	1,555	30,338		30,338		30,338			1
2	Food Purchase		24,219		24,219		24,219	(2,843)	21,376			2
3	Housekeeping		2,436		2,436		2,436		2,436			3
4	Laundry		1,523		1,523		1,523		1,523			4
5	Heat and Other Utilities			9,573	9,573		9,573	64	9,637			5
6	Maintenance	10,389		8,311	18,700		18,700	1,019	19,719			6
7	Other (specify):*											7
8	TOTAL General Services	37,663	29,687	19,439	86,789		86,789	(1,760)	85,029			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	114,803	3,896	2,618	121,317		121,317		121,317			10
10a	Therapy			961	961		961		961			10a
11	Activities		3,900	271	4,171		4,171	1,702	5,873			11
12	Social Services			1,893	1,893		1,893		1,893			12
13	Nurse Aide Training											13
14	Program Transportation			1,499	1,499		1,499		1,499			14
15	Other (specify):* Routine Dental			835	835		835		835			15
16	TOTAL Health Care and Programs	114,803	7,796	9,277	131,876		131,876	1,702	133,578			16
	C. General Administration											
17	Administrative	41,011		41,960	82,971		82,971	(41,960)	41,011			17
18	Directors Fees			81	81		81	3,007	3,088			18
19	Professional Services			2,810	2,810		2,810	6,803	9,613			19
20	Dues, Fees, Subscriptions & Promotions			1,461	1,461		1,461	128	1,589			20
21	Clerical & General Office Expenses	14,138	4,091	4,699	22,928		22,928	9,024	31,952			21
22	Employee Benefits & Payroll Taxes			23,241	23,241		23,241	24,616	47,857			22
23	Inservice Training & Education			194	194		194	299	493			23
24	Travel and Seminar			1,169	1,169		1,169	1,663	2,832			24
25	Other Admin. Staff Transportation			1,012	1,012		1,012	136	1,148			25
26	Insurance-Prop.Liab.Malpractice							4,289	4,289			26
27	Other (specify):*											27
28	TOTAL General Administration	55,149	4,091	76,627	135,867		135,867	8,005	143,872			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	207,615	41,574	105,343	354,532		354,532	7,947	362,479			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7**	8			
30	Depreciation			3,043	3,043		3,043	569	3,612			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,933	2,933		2,933	2,898	5,831			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			69,255	69,255		69,255	1,771	71,026			34
35	Rent-Equipment & Vehicles			9,240	9,240		9,240	807	10,047			35
36	Other (specify):*											36
37	TOTAL Ownership			84,471	84,471		84,471	6,045	90,516			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			269	269		269	381	650			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			30,309	30,309		30,309		30,309			42
43	Other (specify):* Nonallowable costs			144,195	144,195		144,195	(144,195)				43
44	TOTAL Special Cost Centers			174,773	174,773		174,773	(143,814)	30,959			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	207,615	41,574	364,587	613,776		613,776	(129,822)	483,954			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**See schedule of adjustments attached at end of cost report

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(143,759)	43		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(426)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(3,074)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule 5A	(2,099)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (149,358)		\$	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	19,536		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 19,536		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (129,822)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

(See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Sparta Terrace
IDPH # 0036335
6/30/2001

Schedule 5A

VI. Adjustment Detail

<u>Line 29 - Other</u>	<u>Description</u>	<u>Amount</u>	<u>Reference</u>
	Vending expense	(10)	43
	Out-of-period accounting fees	<u>(2,089)</u>	<u>19</u>
	Total	<u><u>(2,099)</u></u>	

SEE ACCOUNTANTS' COMPILATION REPORT

Sparta Terrace

ID# 0036335
Report Period Beginning: 7/1/00
Ending: 6/30/01

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Residential Centers, Inc. - See attached Schedule 7A	100%	See attached Related Party Schedule		See attached Related Party Schedule		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	Repairs & maintenance	\$	Center for Residential Management, Inc.	**	\$ 36	\$ 36	1
2	V	11	Activity programming		Center for Residential Management, Inc.	**			2
3	V	17	Management fees	6,247	Center for Residential Management, Inc.	**	8,170	1,923	3
4	V	18	Board fees		Center for Residential Management, Inc.	**	800	800	4
5	V	19	Professional fees		Center for Residential Management, Inc.	**	1,964	1,964	5
6	V	20	Licenses, dues & subscriptions		Center for Residential Management, Inc.	**	35	35	6
7	V	21	Office supplies & telephone		Center for Residential Management, Inc.	**	5,094	5,094	7
8	V	22	Emp. benefits & payroll taxes		Center for Residential Management, Inc.	**	14,266	14,266	8
9	V	24	Travel & seminar		Center for Residential Management, Inc.	**	459	459	9
10	V	25	Vehicle expense		Center for Residential Management, Inc.	**	30	30	10
11	V	26	Vehicle, fire & liab. insurance		Center for Residential Management, Inc.	**	47	47	11
12	V	30	Depreciation		Center for Residential Management, Inc.	**	311	311	12
13	V	32	Interest expense		Center for Residential Management, Inc.	**	369	369	13
14	Total			\$ 6,247			\$ 31,581	\$ * 25,334	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number	Sparta Terrace	#	0036335	Report Period Beginning:	7/1/00	Ending:	6/30/01
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VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Ancillary service centers	\$	Center for Residential Management, Inc.	**	\$ 381	\$ 381	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V				**Center for Residential Management, Inc. is				21
22	V				Residential Centers, Inc.'s parent company.				22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 381	\$ *	381

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management fees	\$	Residential Centers, Inc.	100.00%	\$ 17,100	\$ 17,100	15
16	V	18	Board fees		Residential Centers, Inc.	100.00%	2,207	2,207	16
17	V	20	Licenses, dues & subscriptions		Residential Centers, Inc.	100.00%	23	23	17
18	V	21	Office supplies & telephone		Residential Centers, Inc.	100.00%	214	214	18
19	V	22	Emp. benefits & payroll taxes		Residential Centers, Inc.	100.00%	5,385	5,385	19
20	V	24	Travel & seminar		Residential Centers, Inc.	100.00%	236	236	20
21	V	26	Vehicle, fire & liab. insurance		Residential Centers, Inc.	100.00%	4,118	4,118	21
22	V	32	Interest expense		Residential Centers, Inc.	100.00%	2,953	2,953	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 32,236	\$ * 32,236	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	\$	Developmental Services of Illinois, Inc.	**	\$ 64	\$ 64	15
16	V	6	Repairs & maintenance		Developmental Services of Illinois, Inc.	**	983	983	16
17	V	11	Activity programming		Developmental Services of Illinois, Inc.	**	1,702	1,702	17
18	V	17	Management fees	60,983	Developmental Services of Illinois, Inc.	**		(60,983)	18
19	V	19	Professional fees		Developmental Services of Illinois, Inc.	**	6,928	6,928	19
20	V	20	Licenses, dues & subscriptions		Developmental Services of Illinois, Inc.	**	42	42	20
21	V	21	Office supplies & telephone		Developmental Services of Illinois, Inc.	**	3,716	3,716	21
22	V	22	Emp. benefits & payroll taxes		Developmental Services of Illinois, Inc.	**	2,150	2,150	22
23	V	23	Inservice education		Developmental Services of Illinois, Inc.	**	299	299	23
24	V	24	Travel & seminar		Developmental Services of Illinois, Inc.	**	968	968	24
25	V	25	Vehicle expense		Developmental Services of Illinois, Inc.	**	106	106	25
26	V	26	Vehicle, fire & liab. insurance		Developmental Services of Illinois, Inc.	**	124	124	26
27	V	30	Depreciation		Developmental Services of Illinois, Inc.	**	258	258	27
28	V	32	Interest expense		Developmental Services of Illinois, Inc.	**	2,650	2,650	28
29	V	34	Rent expense		Developmental Services of Illinois, Inc.	**	1,771	1,771	29
30	V	35	Equipment rental		Developmental Services of Illinois, Inc.	**	807	807	30
31	V								31
32	V								32
33	V								33
34	V				**Developmental Services of Illinois, Inc. is				34
35	V				Residential Centers, Inc.'s management company.				35
36	V								36
37	V								37
38	V								38
39	Total			\$ 60,983			\$ 22,568	\$ * (38,415)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Sparta Terrace # 0036335 Report Period Beginning: 7/1/00 Ending: 6/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Ronald Schroeder	President	Board Member	None	14,189	2 hrs/mtg.		Directors Fees	\$ 611	L18, C8	1
2	Eugene Humphrey	Vice President	Board Member	None	4,533	2 hrs/mtg.		Directors Fees	267	L18, C8	2
3	Edward Childers	Secretary	Board Member	None	14,060	2 hrs/mtg.		Directors Fees	540	L18, C8	3
4	Robert Bauer	Treasurer	Board Member	None	14,289	2 hrs/mtg.		Directors Fees	511	L18, C8	4
5	Darrell Boehne	Director	Board Member	None	14,287	2 hrs/mtg.		Directors Fees	513	L18, C8	5
6	Merla McCloud	Recorder	Administrative	None	17,889	2 hrs/mtg.		Directors Fees	511	L18, C8	6
7	Orland Bauer	Director	Board Member	None	8,687	2 hrs/mtg.		Directors Fees	113	L18, C8	7
8	Duane Satterwhite	Director	Board Member	None	4,778	2 hrs/mtg.		Directors Fees	22	L18, C8	8
9											9
10											10
11											11
12	See attached Schedule 7A										12
13								TOTAL	\$ 3,088		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sparta Terrace# 0036335

Report Period Beginning:

7/1/00Ending: 6/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Center for Residential Management, Inc.Street Address 4239 W. War Memorial Dr., Suite 302City / State / Zip Code Peoria, IL 61614Phone Number (309) 685-0595Fax Number (309) 685-8463

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Repairs & maintenance	Bed days available	205,860	20	\$ 1,284	\$	5,840	\$ 36	1
2	17	Management fees	Bed days available	205,860	20	288,000		5,840	8,170	2
3	18	Board fees	Bed days available	205,860	20	28,200		5,840	800	3
4	19	Professional fees	Bed days available	205,860	20	69,236		5,840	1,964	4
5	20	Licenses, dues & subscriptions	Bed days available	205,860	20	270		5,840	7	5
6	21	Office supplies & telephone	Bed days available	205,860	20	18,491		5,840	525	6
7	22	Emp. benefits & payroll taxes	Bed days available	205,860	20	41,807		5,840	1,186	7
8	24	Travel & seminar	Bed days available	205,860	20	13,361		5,840	380	8
9	25	Vehicle expense	Bed days available	205,860	20	1,044		5,840	30	9
10	26	Vehicle, fire & liab. insurance	Bed days available	205,860	20	1,644		5,840	47	10
11	30	Depreciation	Bed days available	205,860	20	10,967		5,840	311	11
12	32	Interest expense	Bed days available	205,860	20	13,013		5,840	369	12
13	39	Ancillary service centers	Bed days available	205,860	20	13,408		5,840	381	13
14										14
15										15
16										16
17	20	Licenses, dues & subscriptions	Direct method						28	17
18	21	Office supplies & telephone	Direct method						4,569	18
19	22	Emp. benefits & payroll taxes	Direct method						13,080	19
20	24	Travel & seminar	Direct method						79	20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 500,725	\$		\$ 31,962	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sparta Terrace # 0036335 Report Period Beginning: 7/1/00 Ending: 6/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Residential Centers, Inc.
Street Address 4239 W. War Memorial Dr., Suite 302
City / State / Zip Code Peoria, IL 61614
Phone Number (309) 685-0595
Fax Number (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Management fees	Number of beds	193	4	\$ 190,425	\$	16	\$ 17,100	1
2	18	Board fees	Number of beds	193	4	26,625		16	2,207	2
3	20	Licenses, dues & subscriptions	Number of beds	193	4	274		16	23	3
4	21	Office supplies & telephone	Number of beds	193	4	2,583		16	214	4
5	24	Travel & seminar	Number of beds	193	4	2,854		16	236	5
6	32	Interest expense	Number of beds	193	4	35,624		16	2,953	6
7										7
8										8
9										9
10	22	Emp. benefits & payroll taxes	Direct method						5,385	10
11	26	Vehicle, fire & liab. insurance	Direct method						4,118	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 258,385	\$		\$ 32,236	25

Facility Name & ID Number Sparta Terrace # 0036335 Report Period Beginning: 7/1/00 Ending: 6/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Developmental Services of Illinois, Inc.
Street Address 4239 W. War Memorial Dr., Suite 302
City / State / Zip Code Peoria, IL 61614
Phone Number (309) 685-0595
Fax Number (309) 685-8463

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Bed days available	205,860	20	\$ 2,273	\$	5,840	\$ 64	1
2	6	Repairs & maintenance	Bed days available	205,860	20	34,653		5,840	983	2
3	11	Activity programming	Bed days available	205,860	20	60,000		5,840	1,702	3
4	19	Professional fees	Bed days available	205,860	20	244,200		5,840	6,928	4
5	20	Licenses, dues & subscriptions	Bed days available	205,860	20	1,464		5,840	42	5
6	21	Office supplies & telephone	Bed days available	205,860	20	130,977		5,840	3,716	6
7	22	Emp. benefits & payroll taxes	Bed days available	205,860	20	75,816		5,840	2,150	7
8	23	Inservice education	Bed days available	205,860	20	10,547		5,840	299	8
9	24	Travel & seminar	Bed days available	205,860	20	34,127		5,840	968	9
10	25	Vehicle expense	Bed days available	205,860	20	3,724		5,840	106	10
11	26	Vehicle, fire & liab. insurance	Bed days available	205,860	20	4,401		5,840	124	11
12	30	Depreciation	Bed days available	205,860	20	9,100		5,840	258	12
13	32	Interest expense	Bed days available	205,860	20	93,395		5,840	2,650	13
14	34	Rent expense	Bed days available	205,860	20	62,438		5,840	1,771	14
15	35	Equipment rental	Bed days available	205,860	20	28,457		5,840	807	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 795,572	\$		\$ 22,568	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	NCS Healthcare, Inc.		x	Hardware/software	\$145.00	10/31/98	\$ 5,783	\$ 2,484	09/30/03	0.1429	\$ 326	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				\$145.00		\$ 5,783	\$ 2,484			\$ 326	9
	B. Non-Facility Related*											
10							Miscellaneous interest expense				5,560	10
11							Offset interest income				(66)	11
12							Non-allowable interest expense				(3,008)	12
13							Allocated from parent & management company				3,019	13
14	TOTAL Non-Facility Related						\$	\$			\$ 5,505	14
15	TOTALS (line 9+line14)						\$ 5,783	\$ 2,484			\$ 5,831	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

<div>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</div>			
1. Real Estate Tax accrual used on 2000 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <div>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</div>		N/A	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <div>TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</div>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:			
1996		8	
1997		9	
1998		10	
1999		11	
2000		12	
		13	FROM R. E. TAX STATEMENT FOR 2000 \$ 13
		14	PLUS APPEAL COST FROM LINE 5 \$ 14
		15	LESS REFUND FROM LINE 6 \$ 15
		16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sparta Terrace COUNTY Randolph

FACILITY IDPH LICENSE NUMBER 0036335

CONTACT PERSON REGARDING THIS REPORT Rob Keime

TELEPHONE (309) 685-0595 FAX #: (309) 685-8463

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5. <u>N/A</u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS		\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,100

B. General Construction Type: Exterior Wood with siding Frame Wood Number of Stories One

C. Does the Operating Entity? ☐ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred: n/a

2. Number of Years Over Which it is Being Amortized: n/a

3. Current Period Amortization: n/a

4. Dates Incurred: n/a

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>n/a</u>			\$	1
2					2
3	TOTALS			\$	3

XI. OWNERSHIP COSTS (continued)											
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.											
	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$		4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Security alarm system			1994	2,045	136	15	136		1,022	9
10	Carpet			1995	1,301	87	15	87		564	10
11	Replacement of water lines			1995	1,550	103	15	103		594	11
12	Additional water line			1995	1,001	67	15	67		373	12
13	Mixing valve			1998	626	42	15	42		147	13
14	Carpet			1998	1,185	79	15	79		250	14
15	Backflow prevention			1998	1,131	76	15	76		196	15
16	Paint and ceramic tile			1999	827	55	15	55		138	16
17	Second backflow prevention			1999	1,165	78	15	78		168	17
18	Tile			1999	3,116	208	15	208		329	18
19	Shower			1999	1,113	74	15	74		117	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 15,060	\$ 1,005		\$ 1,005	\$	\$ 3,898	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 19,776	\$ 2,038	\$ 2,038		5-10 years	\$ 10,361	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Parent & management company allocation			569	569			74
75	TOTALS	\$ 19,776	\$ 2,038	\$ 2,607	\$ 569		\$ 10,361	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 34,836	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 3,043	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 3,612	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 569	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 14,259	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Community Living Options
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☒ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		16	06/01/00	\$ 69,255	5	5	3
4	Additions							4
5								5
6	Parent & management company allocation				1,771			6
7	TOTAL		16		\$ 71,026			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
- n/a
- n/a
- n/a

9. Option to Buy:
- ☐ YES
- ☒ NO
- Terms: n/a
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☒ NO
16. Rental Amount for movable equipment: \$ 807
- Description: Management company allocation \$807
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Resident care	1996 Century Buick	\$ 770.00	\$ 9,240	17
18					18
19					19
20					20
21	TOTAL		\$ 770.00	\$ 9,240	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? It is the policy of this facility to only hire certified nurses aides If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	2. CLASSROOM PORTION: IN-HOUSE PROGRAM IN OTHER FACILITY COMMUNITY COLLEGE HOURS PER AIDE	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="text"/>	3. CLINICAL PORTION: IN-HOUSE PROGRAM IN OTHER FACILITY HOURS PER AIDE	<input type="checkbox"/> <input type="checkbox"/> <input type="text"/>
---	--	---	--	---	--

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$			1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See attached Schedule 16A				7	269	381	7	650	13
14	TOTAL			\$	7	\$ 269	\$ 381	7	\$ 650	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Sparta Terrace
Provider # 0036335
6/30/2001

Schedule 16A

XIV. Special Services

<u>Line 13 - Other</u>	Service	Sch V	Units	Cost	Supplies
		Line & Col. Reference			
	Emergency Dental	L39, C3	5	130	
	Part B Medicare Supplies	L39, C8			381
	Eye Care	L39, C3	2	139	
			7	269	381

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 738	\$ 738	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>1,219</u>)	52,369	52,369	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	763	763	6
7	Other Prepaid Expenses	31,978	31,978	7
8	Accounts Receivable (owners or related parties)	176,225	176,225	8
9	Other(specify): <u>See attached Schedule 17A</u>	44,255	44,255	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 306,328	\$ 306,328	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	15,060	15,060	15
16	Equipment, at Historical Cost	19,776	19,776	16
17	Accumulated Depreciation (book methods)	(14,259)	(14,259)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 20,577	\$ 20,577	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 326,905	\$ 326,905	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 56,113	\$ 56,113	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	12,059	12,059	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See attached Schedule 17A</u>	21,685	21,685	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 89,857	\$ 89,857	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,484	2,484	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,484	\$ 2,484	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 92,341	\$ 92,341	46
47	TOTAL EQUITY(page 18, line 24)	\$ 234,564	\$ 234,564	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 326,905	\$ 326,905	48

Sparta Terrace
Provider # 0036335
6/30/2001

Schedule 17A

Schedule XV - Balance Sheet

<u>Line 9-Other assets</u>	<u>Operating</u>	<u>After Consolidation</u>
Prepaid Deposits	15,550	15,550
Due From Third Party	28,705	28,705
Total Other Assets	44,255	44,255

<u>Line 36-Other current liabilities</u>	<u>Operating</u>	<u>After Consolidation</u>
Accrued expense	3,055	3,055
Accrued workshop	14,979	14,979
Resident credit balances	3,096	3,096
Accrued insurance payable	555	555
Total Current Liabilities	21,685	21,685

SEE ACCOUNTANTS' COMPILATION REPORT

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 189,284	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 189,284	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	95,270	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Parent & management company		15
16	Other (describe) allocation added back in column 7	(49,990)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 45,280	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 234,564	24 *

Operating entity only
* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 560,341	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 560,341	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education	146,814	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	1,694	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 148,508	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	66	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 66	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Vending Income</u>	131	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 131	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 709,046	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	86,789	31
32	Health Care	131,876	32
33	General Administration	135,867	33
	B. Capital Expense		
34	Ownership	84,471	34
	C. Ancillary Expense		
35	Special Cost Centers	144,464	35
36	Provider Participation Fee	30,309	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 613,776	40
41	Income before Income Taxes (line 30 minus line 40)**	95,270	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 95,270	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
A federal tax return is filed for the combined divisions of Residential Centers, Inc.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	540	540	8,100	15.00	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	2,939	3,299	27,274	8.27	15
16	Dishwashers					16
17	Maintenance Workers	1,075	1,103	10,389	9.42	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,900	2,076	33,909	16.33	20
21	Assistant Administrator					21
22	Other Administrative	296	311	7,102	22.84	22
23	Office Manager					23
24	Clerical	633	656	14,138	21.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	14,237	15,272	106,703	6.99	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	21,620	23,257	\$ 207,615 *	\$ 8.93	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	28	\$ 1,555	L1, C3	35
36	Medical Director	Monthly	1,200	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	164	L10, C3	39
40	Physical Therapy Consultant	2	83	L10A, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	14	878	L10A, C3	43
44	Activity Consultant				44
45	Social Service Consultant	38	1,893	L12, C3	45
46	Other(specify)				46
47	Psychological Consultant	Monthly	2,454	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	82	\$ 8,227		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses		n/a		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Sparta Terrace
IDPH # 0036335
6/30/2001

Schedule 21C

XIX. Support Schedules
C. Professional Services

Total (agree to Schedule V, line 19, column 3)			2,810
Allocated from parent company			
Mangum, Smietanka, & Johnson	Legal		660
Lawrence Manson	Legal		382
Altschuler, Melvoin & Glasser LLP	Accounting		613
American Express Tax & Business Services	Accounting		309
Allocated from management company			
Altschuler, Melvoin & Glasser LLP	Accounting		1,472
American Express Tax & Business Services	Accounting		702
ADP	Payroll		2,549
Health Outcomes	Consulting		116
Total (agree to Schedule V, line 19, column 8)			<u>9,613</u>

SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9	N/A												
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Association \$864
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? n/a
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? n/a
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? n/a
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line n/a
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. n/a
- (9) Are you presently operating under a sublease agreement? YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
n/a
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 30,309
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 2,843 Has any meal income been offset against related costs? No Indicate the amount. \$ n/a
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ n/a
c. What percent of all travel expense relates to transportation of nurses and patients? 57%
d. Have vehicle usage logs been maintained? Adequate records are maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ n/a
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Altschuler, Melvoin & Glasser LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit currently in progress.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? n/a
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustmen	Adjusted Total
1. Dietary	27,274	1,509	1,555	30,338	0	30,338	0	30,338
2. Food Pr	0	24,219	0	24,219	0	24,219	-2,843	21,376
3. Housek	0	2,436	0	2,436	0	2,436	0	2,436
4. Laundry	0	1,523	0	1,523	0	1,523	0	1,523
5. Heat an	0	0	9,573	9,573	0	9,573	64	9,637
6. Mainten	10,389	0	8,311	18,700	0	18,700	1,019	19,719
7. Other (s	0	0	0	0	0	0	0	0
8. Total Gr	37,663	29,687	19,439	86,789	0	86,789	-1,760	85,029
9. Medical	0	0	1,200	1,200	0	1,200	0	1,200
10. Nursin	114,803	3,896	2,618	121,317	0	121,317	0	121,317
10a. Ther:	0	0	961	961	0	961	0	961
11. Activiti	0	3,900	271	4,171	0	4,171	1,702	5,873
12. Social	0	0	1,893	1,893	0	1,893	0	1,893
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	1,499	1,499	0	1,499	0	1,499
15. Other	0	0	835	835	0	835	0	835
16. Total f	114,803	7,796	9,277	131,876	0	131,876	1,702	133,578
17. Admin	41,011	0	41,960	82,971	0	82,971	-41,960	41,011
18. Direct	0	0	81	81	0	81	3,007	3,088
19. Profes	0	0	2,810	2,810	0	2,810	6,803	9,613
20. Fees,	0	0	1,461	1,461	0	1,461	128	1,589
21. Cleric:	14,138	4,091	4,699	22,928	0	22,928	9,024	31,952
22. Emplo	0	0	23,241	23,241	0	23,241	24,616	47,857
23. Inservi	0	0	194	194	0	194	299	493
24. Travel	0	0	1,169	1,169	0	1,169	1,663	2,832
25. Other .	0	0	1,012	1,012	0	1,012	136	1,148
26. Insura	0	0	0	0	0	0	4,289	4,289
27. Other	0	0	0	0	0	0	0	0
28. Total C	55,149	4,091	76,627	135,867	0	135,867	8,005	143,872
29. Total C	207,615	41,574	105,343	354,532	0	354,532	7,947	362,479
30. Depre:	0	0	3,043	3,043	0	3,043	569	3,612
31. Amorti	0	0	0	0	0	0	0	0
32. Interes	0	0	2,933	2,933	0	2,933	2,898	5,831
33. Real E	0	0	0	0	0	0	0	0
34. Rent -	0	0	69,255	69,255	0	69,255	1,771	71,026
35. Rent -	0	0	9,240	9,240	0	9,240	807	10,047
36. Other	0	0	0	0	0	0	0	0
37. Total C	0	0	84,471	84,471	0	84,471	6,045	90,516
38. Medica	0	0	0	0	0	0	0	0
39. Ancilla	0	0	269	269	0	269	381	650
40. Barber	0	0	0	0	0	0	0	0
41. Coffee	0	0	0	0	0	0	0	0
42. Provid	0	0	30,309	30,309	0	30,309	0	30,309
43. Other	0	0	144,195	144,195	0	144,195	-144,195	0
44. Total S	0	0	174,773	174,773	0	174,773	-143,814	30,959
45. Grand	207,615	41,574	364,587	613,776	0	613,776	-129,822	483,954

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on	738	738
2. Cash - F	0	0
3. Account	52,369	52,369
4. Supply I	0	0
5. Short-Te	0	0
6. Prepaid	763	763
7. Other Pr	31,978	31,978
8. Account	176,225	176,225
9. Other (s	44,255	44,255
10. Total ci	306,328	306,328
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	0	0
13. Land	0	0
14. Buildin	0	0
15. Leaseh	15,060	15,060
16. Equipm	19,776	19,776
17. Accum	-14,259	-14,259
18. Deferre	0	0
19. Organi	0	0
20. Accum	0	0
21. Restric	0	0
22. Other L	0	0
23. other (s	0	0
24. Total L	20,577	20,577
25. Total A	326,905	326,905
CURRENT LIABILITIES		
26. Accour	56,113	56,113
27. Officer'	0	0
28. Accour	0	0
29. Short-T	0	0
30. Accrue	12,059	12,059
31. Accrue	0	0
32. Accrue	0	0
33. Accrue	0	0
34. Deferre	0	0
35. Federa	0	0
36. Other C	21,685	21,685
37. Other C	0	0
38. Total C	89,857	89,857
LONG TERM LIABILITES		
39.Long-Te	2,484	2,484
40.Mortgaç	0	0
41.Bonds F	0	0
42.Deferre	0	0
43.Other L	0	0
44.Other L	0	0
45.Total Lc	2,484	2,484
46.Total Li:	92,341	92,341
47.Total Et	234,564	234,564
48.Total Li:	326,905	326,905

	Balance per	
	Medicaid	
	Trial Balance	
1. Gross F	560,341	
2. Discour	0	
Subtota	560,341	
4. Day Ca	0	
5. Other C	0	
6. Therap	0	
7. Oxygen	0	
Subtota-		
9. Paymer	146,814	
10. Other	0	
11. Nurse	1,694	
12. Gift an	0	
13. Barbei	0	
14. Non-P	0	
15. Teleph	0	
16. Rental	0	
17. Sale o	0	
18. Sale o	0	
19. Labor	0	
20. Radiol	0	
21. Other	0	
22. Laund	0	
Subtot	148,508	
24. Contri	0	
25. Intere	66	
Subtot	66	
27. Other	0	
28. Other	131	
Subtot	131	
30. Total F	709,046	
31. Gener	1,097,314	
32. Health	2,305,427	
33. Gener	2,172,003	
34. Owner	1,099,498	
35. Specie	1,811,922	
35. Provid	406,812	
37. Other	0	
40. Total E	8,892,976	
41. Incom	#####	
42. Incom	0	
43. Net In	#####	

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10 Attachment of Real Estate Bill and fill out form

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12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached

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19 The bottom right side of page under **, you must write in any comments

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RECONCILIATION REPORT				Sparta Terrace		04:12 PM		11/07/05					
ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-129,822	equal to	-129,822	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	5,831	equal to	5,831	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	n/a	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	3,612	equal to	3,612	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	71,026	equal to	71,026	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	10,047	equal to	10,047	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	961	equal to	961	0	O.K.	Pg16 Z12+Z14..	N/A,B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	381	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	86,789	equal to	86,789	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	131,876	equal to	131,876	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	135,867	equal to	135,867	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	84,471	equal to	84,471	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	144,464	equal to	144,464	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+†	N/A	38to41+43	4
Income Stat. Prov. Partic.	30,309	equal to	30,309	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	114,803	equal to	114,803	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	0	equal to	0	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	0	equal to	0	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	27,274	equal to	27,274	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	10,389	equal to	10,389	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	0	equal to	0	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	0	equal to	0	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	41,011	equal to	41,011	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	14,138	equal to	14,138	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	207,615	equal to	207,615	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	1,555	< or = to	1,555	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	1,200	< or = to	1,200	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	164	< or = to	2,618	-2,454	O.K.	Pg20 X14..X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	271	-271	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	1,893	< or = to	1,893	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	41,011	equal to	41,011	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	41,960	equal to	41,960	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	2,810	equal to	2,810	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	47,857	equal to	47,857	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	1,589	equal to	1,589	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	2,832	equal to	2,832	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	30,309	equal to	30,309	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	2,843	< or = to	24,616	-21,773	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	2,843	equal to	2,843	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	n/a	equal to	0	#VALUE!	#VALUE!	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	19,536	equal to	19,536	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6l Y4(B.	14	8
Total loan balance	2,484	equal to	2,484	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to	0	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	0	equal to	0	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	15,060	equal to	15,060	0	O.K.	Pg12 to 12l L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	19,776	equal to	19,776	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	14,259	equal to	14,259	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	234,564	equal to	234,564	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	95,270	equal to	95,270	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	326,905	equal to	326,905	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1